DEPARTMENT OF THE NAVY
NAVAL HOSPITAL
BOX 788250
MARINE CORPS AIR GROUND COMBAT CENTER
TWENTYNINE PALMS, CALIFORNIA 92278-8250

IN REPLY REFER TO:
NAVHOSP29PALMSINST 6301.1A
Code 0400
2 July 1997

NAVAL HOSPITAL TWENTYNINE PALMS INSTRUCTION 6301.1A

From: Commanding Officer

Subj: CONSCIOUS SEDATION POLICY FOR THE TWENTYNINE PALMS NAVAL HOSPITAL

Ref: (a) Accreditation Manual for Hospitals, 1997
(b) BUMEDINST 6320.66A
(c) BUMEDINST 6010.17A

Encl: (1) Guidelines for Conscious Sedation in Ambulatory Patients
(2) Medications list and dosage guide
(3) ASA physical status definitions
(4) Qualifications/Competency of sedation monitoring personnel
(5) Qualification/Competency of the operator
(6) Preoperative Assessment record
(7) Anesthetic/Sedation record
(8) Required monitoring parameters/equipment
(9) Patient release criteria/form
(10) Indicator Data Report Form
(11) Record of Conscious Sedation Course Completion

1. Purpose. To establish standards for the conduct of conscious sedation in an ambulatory care setting. To integrate conscious sedation into performance improvement, to provide a mechanism for continuous improvement in quality of patient care in compliance with references (a), (b) and (c).

2. Cancellation. NAVHOSP29PALMSINST 6301.1.

3. Background. Sedation, deep sedation and general anesthesia represent a continuum of responses seen in patients receiving a drug (or a combination of drugs) designed to depress consciousness and/or reduce perception of pain. The degree of depression/pain-relief depends on factors which include: dosage of drug, route and rate of administration, combination with other agents and patient factors such as age, weight, current medications, alcohol intake patterns and medical condition. Experience and knowledge of the pharmacology of drugs are required to provide effective conscious sedation without progression to deep sedation and general anesthesia. Enclosure (l) offers guidelines on selection and dosage of commonly used agents for conscious sedation. Provision of deep sedation and general anesthesia is limited to providers who are credentialed in anesthesia (or trainees directly supervised by an anesthesia provider).

5. Applicability

a. This instruction applies when a patient (in any setting) receives sedation (and/or analgesia) for which there is a reasonable expectation that, in the manner or dosage used, the sedation/analgesia can or may result in the loss of protective reflexes for a significant percentage of a group of patients. This includes patients where repair or removal of a painful stimulus may cause them to lapse into deep sedation or minimal responsiveness from medications previously administered. This instruction does not apply to patients where a minimal use of a single pain relief medication, without any combination with a sedating or anxiolytic medication, clearly and without doubt allows protective reflexes to be maintained, retains the patient's ability to maintain a patent airway, independently and consciously, and permits appropriate response by the patient to all physical stimulation or verbal commands.

b. This instruction applies to routine and urgent cases. (Emergencies are to be handled by the Anesthesia Department or Emergency Medicine Department). Documentation in the medical record (should be the Pre-Sedation Form, enclosure (6)), by the provider, of the rationale for the planned choice of sedation, with or without analgesia, or documentation of a credentialed anesthesia provider's recommendations is required. Enclosure (3) defines ASA classes/examples.

c. The facility specific settings, where the appropriate monitoring/resuscitation equipment is continuously available, (see enclosure (8), for use by providers other than Anesthesia staff, will include the Emergency Department, the Main Operating Room and the PACU. Anesthesia providers will do al sedation procedures at other sites.

Pediatric Patients: Consultation with a credentialed anesthesia provider is required for children whose age is < 5 years or weight is <50 lbs. Age appropriate resuscitative training is required if anesthesia personnel are not present to assist. Per memorandum from Pediatric Department, Anesthesia will be performing all routine pediatrics conscious sedation cases.

5. Definitions

a. Conscious sedation is an altered level of consciousness produced by a drug or drugs, administered by intravenous or other routes, in a manner intended and expected to reduce the patient's response to noxious stimuli. It may also provide anxiolysis and amnesia while retaining protective reflexes and the ability to respond to verbal commands. Conscious sedation is administered for patient safety and comfort during procedures performed

outside the normal anesthetizing locations. The primary distinction between conscious sedation and anesthesia is that, in conscious sedation, no loss of protective reflexes is expected or intended. In deep sedation and general anesthesia, loss of those reflexes is expected and prepared for.

b. Loss of protective reflexes occurs when the patient is unable to react in a timely and appropriate manner to a stimulus were it not for presence of sedation/analgesia in the patient's system. Examples of reflex losses include:

(1) Patient requires repeated prompting to take breaths, or has prolonged apneic episodes.

(2) Ineffective gag reflex, causing aspiration risk.

(3) Inability to respond appropriately to external stimuli; such as the ability to follow reasonable commands during the procedure, or, likely inability to respond to an external threat such as a building or facility fire.

c. Monitor. The monitor is the individual responsible for direct observation and documentation of the physiologic and psychologic status of the patient. The qualifications of the individual are delineated in enclosure 94). The monitor may not simultaneously or intermittently serve as a scrub tech, circulating nurse, or assistant during the procedure.

d. Operator. The operator describes the person who defines the need for conscious sedation for the patient, consults the patient or guardian regarding the administration of the medication(s), orders those medications administered in appropriate dosage and timing, performs the operative, invasive or other procedure and serves as the overseer of the process. Enclosure (5) lists the facility specific requirements for the operator.

e. Operative, invasive, and "other procedures" describes those procedures involving puncture or incision of the skin or insertion of an instrument or foreign material into the body, including, but not limited to, percutaneous aspirations and biopsies, cardiac and vascular catheterization, endoscopies, and other manipulations excluding venipuncture and intravenous therapy. "Other procedures" refer to non-invasive manipulations such as reductions of fractures and dislocations and certain radiological studies requiring sedation. These procedures are not expected to involve significant blood loss, involve intracavitary exploration, or incur hypothermia.

6. Standard of care. The standard of care that will apply to patients governed by this instruction consists of four key elements which will be practiced and documented in the medical

record. This facility will use the standard (enclosure 6) pre-sedation form for preoperative evaluation and the standard (enclosure (7)) anesthetic form for logging of medications, treatments, vital signs and the recovery period.

a. Patient Assessment. Selection of the appropriate procedure for the patient will include consideration of the following:

(1) Patient's medical, anesthetic and drug history.

(2) The physical status of the patient.

(3) Pertinent diagnostic data and laboratory test results.

(4) The risks/benefits of the procedure itself.

b. Patient preparation. Informed consent will be given so the patient, and documented in the record, in the following areas:

(l) Indications, alternatives, and risks of the procedure.

(2) Indications, alternatives, and risks of sedation, fully and clearly discussed with the patient or guardian, and a handwritten notation of the scope of this discussion in the progress notes or on the bottom of the anesthesia pre-op/pre-sedation evaluation form.

(3) Need for, and risks of, blood transfusion and alternatives, if applicable.

c. Peri-operative observation of the patient. Required equipment for the peri-operative observation to include the recovery phase is found in enclosure (8). The patient will be monitored from the beginning of the sedation through the end of the recovery period. Parameters monitored or recorded will include:

(1) Physiologic and psychologic status including those listed in enclosure (8).

(2) Amount of intravenous fluids (including blood and blood products), and the type and dose of drugs administered.

(3) Description of peri-operative complications, from both the procedure and/or the sedation given.

(4) Assessment of the patient prior to release from the recovery phase/area.

d. Patient/release. The patient may be released from the recovery phase/area by the physician or dentist or by departmental criteria which must include the criteria listed on enclosure (9).

7. Performance Improvement

a. Each clinical area (department will incorporate the provisions of this instruction and indicators into their current PI plan.

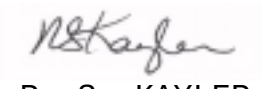
b. Interim indicator monitoring data will be collected using enclosure (l0). Departments will begin submitting enclosure (10), one monthly copy for each provider performing conscious sedation, beginning 30 days after the date of this instruction.

c. The department head of Anesthesiology will review and analyze the indicator data of enclosure (10) quarterly, and provide conclusions and recommendations for improvement to relevant departments. A summary report will be presented at the Morbidity and Mortality meetings.

d. An anesthesia provider will present a review lecture for operators and monitors at least yearly or as often as is practical, if requested. This course will focus on airway management, physiologic monitoring, and the use and dosing of sedation/analgesic medications.

8. Revision. The Executive Committee of the Medical Staff will review this instruction annually. Revisions or improvements will be based on the results of the quarterly summaries, conclusions, ongoing reviews of other departmental PI data, as needed, with Department head, ECOMS and Board of Director recommendations included:

9. Forms. NAVHOSP29PALMS Form 6320/79 (Rev. 12/96) (Pre and Post Sedation Evaluation Summary) and NAVHOSP29PALMS Form 6320/78 (Rev. 12/96) (Anesthesia Record) are being adopted by this instruction and are available in Central Files.



R. S. KAYLER

Distribution:
List A

Guidelines for Conscious Sedation in Ambulatory Patients

1. These guidelines are intended to provide assistance in the understanding of the use of medications to produce decreased anxiety, provide analgesia and/or amnesia, in ambulatory patients undergoing examinations or minor surgical procedures.

2. The sedation/analgesia requirements in a particular situation depend on many factors including the likely degree of discomfort, the duration of the major stimulus, the necessity of the patient to be alter enough to cooperate, and various emotional considerations.

3. Patient responsiveness to the procedure or the effectiveness of the medication is subject to cultural factors as well as age, and individual levels of tolerance of discomfort.

4. Special consideration should be given to age, physical condition, exercise tolerance, ethanol intake and other medications routinely used by the patient, as these can result in unexpected resistance or sensitivity to the sedation/analgesia medications commonly used.

5. The following are the recommended first line drugs, given I.V., with representative incremental and total doses over 30-60 mins. for an average size adult (70-80kg):

Drug	Incr. Dose	Max Dose mg (mg/kg)	Onset (min)	Duration	Precautions
Morphine	1-2 mg q 5min	10 (0.10-.15)	1-2 min	30-60 min	long acting releases
Demerol	10-20mg q 5min	100 (1-1.5)	1-2 min	20-40 min	mod long acting
Fentanyl (Nacotic)	25 mcg q 3min	200mcg (2-3 mcg/kg)	1 min	10-15 min	100xmorphine potency
Midazolam Benzodiazepin	0.5mg q 3min	2-10 (.05-.1)	1-3 min	15-30 min	Potentiates narcotics

Medications should be titrated carefully until the desired effect is obtained. Reduce the incremental size and total dose given in old very ill patients. Young, vigorous individuals may require greater than typical doses. When larger total doses have been given, patients may be come very sedated after the stimulus of surgery has ceased. Monitor for apnea and airway obstruction.

6. The following medications have been used in the past but are considered to have specific difficulties associated with their use, and are therefore inferior to newer medications. However, providers familiar with their use may wish to continue to use them.

a. Diazepam (Valium). 1-2 mg (max. 0.15 mg/kg). Unreliable sedation and amnesia. May produce recurring sedation intermittently for days. Never use I. M.

b. Pentobarbital (Nembutal. 100 mg. Prolonged action, "hangover".

c. Nalbuphine (Nubain). 10-20 mg.

d. Butorphanor Stadol). 1-2 mg. May have less respiratory depression but otherwise no advantage over established narcotics. Longer acting (3-4 hours).

7. The following medications may be needed for specific purposes:

a. Atropine. 0.01 ,g/kg; for bradycardia or to dry secretions.

b. Promethazine. 25-50 mg; for mild allergic reactions or nausea.

c. Droperidol. 0.25-0.625 mg; as an anti-emetic. May decrease BP, as it is an alpha-1 blocker.

d. Labetalol. 5 mg increments, to 2mg/kg for hypertension and tachycardia. Contraindicated in asthmatics.

e. Narcan. 0.1-0.2 mg; to reverse all aspects of narcotics. CAUTION! May need repeating. Serious untoward responses may occur. Completely reverses all narcotic effects including analgesia. BEST USE: dilute one vial (.4mg=400micrograms) in 10cc N.S. and give 1cc/40mcg every 30-45 seconds until desired effect is seen. Lasts 45 minutes. Morphine/Demerol can last longer, and resedation or apnea can recur. Occasional strange behavioral responses and agitation.

f. Flumazenil. 1.0 mg to reverse effect of midazolam or diazepam. Very expensive. Resedation may occur.

8. All medications are given by slow intravenous injection with close observation of the patient for the response. Caution should be exercised if more than one medication is used, as effects usually are additive or potentiating.

Medications

1. The medication listed below, when titrated to a total dose in excess of the range listed, can be expected to result in depression of protective airway reflexes, and therefore cause need for the patient to be monitored in accordance with this instruction.

2. The provisions of this instruction also apply when:

a. The medications listed below are given in combination, irrespective of dosage.

b. The patient's age is <5 yrs or >65 yrs.

c. The patient is taking any other sedative medications.

Medications	Doses
Diazepam	0.15 mg/kg IV
Droperidol	50 mcg/kg IV
Midazolam	70 mcg/kg IV
Meperidine	1 mg/kg IV
Morphine	0.1 mg/kg IV
Fentanyl	2 mcg/kg IV
Chloral Hydrate	50 mg/kg PO or Parenteral
*Ketamine	1.0-3.0 mg/kg IM 0.1-0.5 mg/kg IV, titrated

The practitioner is advised to avoid a routine dose of medications for all patients. Although clinical experience may show this approach to be effective, such action fails to take into consideration individual patient variability in pharmacokinetics and pharmacodynamics. Careful slow titration of medications to the desired effect and continuous observation by an experienced clinician is the cornerstone of safe practice. The clinician must always be ready to increase the level of monitoring and support as the situation dictates.

*Use of this medication in any dosage requires compliance with the instruction, and consult with anesthesia is strongly recommended. Although an excellent analgesic of short duration, it can produce hallucinations, flashbacks, nightmares, hypertension and excessive salvation. Pretreatment with low dose Midazolam may decrease the psychiatric side effects. The dosage listed is merely a usage guideline.

American Society of Anesthesiologists Physical Status Classification

Class I
There is no organic, physiologic, biochemical or psychiatric disturbance. The pathologic process for which operation is to be performed is localized and is nit a systemic disturbance. (ie: healthy pt. for tonsillectomy, colonoscopy or vasectomy.)

Class II
Mild to moderate systemic disturbance caused either by the condition to be treated surgically or by other pathophysiological processes. (ie: HTN, diabetes, pregnancy, smoking; not severe.)

Class III
Severe systemic disturbance or disease from whatever cause, even though it may not be possible to define the degree of (ie: severe hypertension, angina, renal failure/dialysis, COPD, pneumonia)

Class IV
Indicative of the patient with severe systemic disorder already life-threatening, not always correctable by the operative procedures. (ie: acute MI, spesis, shock, trauma)

Class V
The morbund patient who has little chance of survival but is submitted to operation in desperation.

Qualifications/Competence of the Monitor

1. The function of the monitor is direct continuous observation and documentation of the physiologic and mental status of the patient.

2. Ensuring the monitor is qualified in the responsibility of the operator.

3. Who may function as a monitor:

a. A physician or dentist may function as a monitor by virtue of their credentials providing they have:

(1) Currency in BLS

(2) Currency in ACLS

b. A registered nurse, nurse practitioner or physician assistant may function as a monitor upon satisfaction of the following qualifications:

(1) Currency in BLS

(2) Currency in ACLS

(3) Completion of a 1 hour conscious sedation training class.

4. Data may be recorded by a hospital corpsman under the direct supervision of an appropriate monitor providing the corpsman has completed the conscious sedation training class and has passed the rhythm recognition portion of the ACLS class.

5. Evidence of monitor and corpsman competency will be kept in the form of a record of completion of the required training as delineated above; this training will need to be updated every two years, (encl (11)).

Qualifications of the Operator

1. Who may function as the operator:

a. Providers, holding current privileges for the procedure, may function as the operator.

b. Podiatrists, holding current privileges for the procedure, may function as the operator, with the cognizance and written approval of a current staff physician, who is also qualified to do that procedure.

2. Additional required qualifications:

a. Each provider must have in writing, as a supplemental privilege, evidence of completion of the initial training course prior to performing conscious sedation, (enclosure (11)). This completed form will be maintained in the provider's competency file.

b. Each operator, once initially trained, will need to perform two procedures as an operator semi annually or repeat the initial training course to maintain currency.

c. Each provider must have currency in age appropriate advance life support training for the patient they are treating; ACLS, PALS, or NALS.

3. The basic training course for conscious sedation will be taught by an anesthesia provider, and will cover the content of this instruction. Minimum requirements include definitions, locations where conscious sedation is permitted, required monitoring requirements, recommended medications (drug, dose, route and precautions), required paperwork documentation, and performance improvement.

PRE and POST ANESTHETIC EVALUATION/SUMMARY

OPERATION PROPOSED	AGE	CURRENT WEIGHT Lbs. Kg. Height	NPO STATUS: AIR WAY ROM TEETH **ANESTHESIA PLAN** BLOOD N/A T & S T & C
		PHYSICAL STATUS 1 2 3 4 5 E	

URINALYSIS: N/A HCG + / - N/A	HEMATOLOGY: N/A	BLOOD CHEMISTRY: N/A

RESPIRATORY SYSTEM	CIRCULATORY	CENTRAL NERVOUS SYSTEM	OTHER SYSTEMS
TOBACCO _____ ppd x _____yrs. ASTHMA HX: BRONCHITIS COPD PNEUMONIA TB / +ppd URI Cough Productive + / - PE + / - CXR	BP _____ PULSE _____ HIGH / LOW BP R.F. CARDIAC ANGINA MI HX: MURMUR C.F. HX: CLAUDICATION SOB/ORTHOP/PND PE +/- EKG: Exer. Tol:	Hx of; CVA / TA / SZ: Hx of; TRAUMA / MVA /LOC: NECK / BACK PROB / INJ: OTHER CONDITIONS (ARTHRITIS/SCOLIOSIS) NEURO DEFICIT(S); + / - DESCRIBE:	ALLERGIES: Describe Reaction ENDOCRINE DM THYROID LIVER HEPATITIS ETOH RENAL GI ULCERS HIATAL HERNIA HEART BURN GEST. WKS.: _____ G: _____ P: _____ FHT: _____

PREVIOUS ANESTHETICS AND COMPLICATIONS **FAMILY HISTORY OF ANESTHESIA COMPLICATIONS: YES / NO**	PRESENT DRUG THERAPY
PREOPERATIVE DIAGNOSIS 1) 2) 3) 4) 5) 6)	PREMEDICATION SIGNATURE OF EVALUATING PROVIDER / DATE

PRINT OR STAMP: NAME RANK & CORPS

RISK / BENEFITS COUNSELING STATEMENT

DISCHARGE INFORMATION:

a. Discharge to: home ward other (specify) _____
b. Condition: vital signs BP ___/___ HR _____ RR _____
O2 sat (off 02) _____% Temp _____
Pain level (1-10/10) _____ Alert Drowsy Sedated
Ambulatory Wheelchair
c. Operative Site: dry trace bld Mod bld Other _____
d. Accompanied by: spouse relative friend unit rep.
e. Total Fluids; _____cc LR NS EBL _____cc
f. Follow-up instructions: _____
g. "I understand the above instructions" _____
Patient Signature

AGENT(S) ↓ TIME →

l/m N_2O

l/m OXYGEN

CO_2 ABSORP

3-L / 5-L Temp

SK / N / ES EKG

FHT

O_2 Sat

Level Blk.

_____ y.o. M / F

WT: _____

ALLERGIES:

ASA:

I / II / III / IV / E

200
180
160
140
120
100
80
60
40

CODES	
●	Pulse
V	BP Cuff
∧	
⊥	BP Art In
T	
T	Tour
▲	Map

RESPIRATIONS	
O	Spont
◑	Assist
⊗	Ventil

VT

RR

PIP/PEEP

NUMBERS FOR REMARKS

(L) ____ ga

IV FLUIDS

(R) ____ ga

U.O.

POSITION

EBL

TECHNICS/AGENTS

Machine Check done? Y / N

_____ IN O.R.

_____ IND / BLOCK

_____ TO SURG. TEAM

_____ CUT TIME

_____ CLOSE TIME

_____ TO ANESTH. TEAM

_____ ANESTH. END TIME

INDUCTION:

UTERINE INCSN:

DEL:

SEX: M / F

APGAR _____ / _____

PITOCIN _____ u in _____ cc.

O_____

ANTIBIOTIC _____

GIVEN AT

NARCOTICS ISSUED:

AMOUNT USED:

AMOUNT WASTED:

OBSERVED BY:

ANESTHESIA TYPE:
GEN: ETT / LMA / MASK
REGIONAL: SAB / EPID x2 x3
ITN / +LOCAL
MAC / LOCAL

Monitors:

EKG	PCS/ES	BPC
FiO_2	Temp	PNS
SARA	O_2 Sat	Aline
CVP/SG	$EtCO_2$	Foley
Other	FHT	TOCO

INTUBATION NOTES: ETT SIZE:____ LARYNG BLADE: ____ ORO / NASO CUFF PRESS: ____ ETT cm ____@ TEETH/ LIPS / NARE EYES: OINT / TAPE STYLET: Y / N BITE BLOCK: Y / N

POSITION REMARKS:

OPERATION PERFORMED

EPIDURAL / ITN / C-SEC / PPTL

FLUIDS

LR/NS = _____

COLLOID = _____

BLOOD = _____

URINE OUTPUT = _____

EBL = _____

NAME(S) OF SURGEON(S)

_____

_____

Signature of Anesthetist

PRINT NAME, RANK, CORPS

PACU ENTRY TIME [ ]

BP

P

RESP

O_2 SAT

TEMP

MENTAL CONDITION

0_2 Y N

PATIENT'S IDENTIFICATION

(OB) ANESTHESIA RECORD Page __ of __

ABG FiO_2 pH pCO_2 %Sat BE Hgb

OR #

DATE ____ / ____ / ____

Monitoring Parameters/Equipment

1. All patients undergoing sedation with or without analgesia as defined by this instruction will have these minimum physioloigic parameters monitored:

a. Heart rate, blood pressure, and respiratory rate should be checked at 3 minute intervals and values recorded at five (5) minute intervals. A stethoscope, available for monitoring heart rate, respiratory rate, and adequacy of tidal volume is considered essential, and must be present.

b. Oxygen saturation will be monitored non-invasively, on a continuous basis, by pulse oximery, with the pulse tone and pitch clearly audible to all those involved in the procedure, throughout the procedure and recovery period, and the audible alarm trigger set at 90% saturation.

c. Airway will be continuously monitored to ensure continuity and pattern of respirations: this can be audible adequate respirations, vocal responses, etc.

d. Temperatures will be monitored for procedures over one hour in duration; episodic readings of axillary or tympanic membrane temperatures are adequate, and will be logged as such on the record. (ie; AX temp or TM temp).

e. Level of consciousness will be continually assessed: through response to verbal or other stimuli. Close observation of the patient, at all times, is paramount. Verbal, physical or procedural stimuli will be used as needed to supplement and confirm this direct observation of the consciousness level of the patient.

f. A cardiac monitor (3 lead ecg, at minimum) must be monitored throughout the procedure and recovery periods.

2. Documentation of monitoring is to be recorded on enclosure (7); the anesthetic record.

3. The original pre-op and anesthetic records always go into the patients chart, and a copy of the pre-op evaluation and anesthetic record are to be forwarded via your department head to the anesthesia department head for review and maintenance in provider files. Should implications arise, these records are expected to be available for a 1 year period after the procedure has been performed; for review, evaluation and privileging purposes.

Required Equipment for sedation with or Without Analgesia

1. Addition to the equipment appropriate to the procedure, the following equipment is required in the immediate area when sedation with or without analgesia as defined by this instruction is employed from the beginning or the sedation through the recovery phase.

a. Oxygen delivery. A self-inflating positive pressure oxygen delivery system capable of delivering 90% oxygen at least 15 liters per minute flow for at least 60 minutes must be immediately available (2 E cylinders +ambu-bag or Jackson-Reese setup). Various bag and mask sizes should be available to accommodate the anticipated range of patient sizes. Oral and nasal airways, tongue blades, and other airway adjuncts should be immediately available.

b. Oxygen use. Supplemental oxygen is administered routinely to all patients undergoing sedation unless considered inappropriate by the operator. This is a mark or nasal cannula: at a 2-10 1/m flow rate, as appropriate.

c. Suction. A source of suction must be immediately available with a vacuum capacity of 20 inches of mercury or flow capability of 100 liters per minute, with a minimum orifice size of 14 millimeters, (the suction hose).

d. Crash cart. An emergency "crash cart" must be readily available within the department, and should include the necessary drugs and equipment to provide Advance Cardiac Life Support to the patient until stabilized or transferred to a general or special care unit. The standard crash cart is acceptable.

e. Pulse oximeter. A pulse oximeter for non-invasive, continuous monitoring or oxygen saturation is required.

f. A cardiac monitor must be used. Portable types suffice.

g. Phone. A reliable means of two-way communication to summon help is required. In addition to emergency numbers, means for notification of additional support services such as respiratory therapy, the on-call anesthesiologist, etc.; should be noted from the Plan of the Day.

Patient Release Criteria

1. Patients having undergone sedation with or without analgesia as defined by this instruction should meet the following criteria to be considered eligible for release from the recovery phase/area.

a. Alert and oriented to person, time, and place (as appropriate; unless patient has specific preprocedure condition or disability.)

b. Stable vital signs, and SaO2 stable, for at least 15 minutes, at $\geq$97% with supplemental oxygen, for inpatients, and SaO2 stable $\geq$96%, without oxygen or at their documented, pre-procedure, room air normal SaO2, (without sedating/analgesic medications prior to the procedure.)

c. Pain under control and may be managed with oral medication: (the patient agrees).

d. No significant nausea. No vomiting, as evidenced by no enesis for $\geq$60 min, if prior emesis has occurred.

2. Written and verbal release instructions will be given to the patient to include explanation of potential post-procedure effects and any limitations on activities. Patients should be advised not to drive or operate machinery within 24 hours of having a long acting sedative/hypnotic.

3. Patients should be released in the company of a responsible adult, who is capable of transporting them to their quarters/home, and is able to assist them should they need help.

4. 24 hour emergency contact numbers will be provided to the patient at the time of release. These will be the departmental person on call (via the front desk if needed), and the Emergency Department.

5. Inpatients may be returned to their ward/room, when considered stable, and are judged to be acceptable for routine ward monitoring.

6. Written documentation of release criteria will be recorded on the bottom of Enclosure (6), (the pre-op assessment sheet) and these will include:

a. Discharge to: home, ward, or other (specify).

b. Condition: pain level: 1 - 10/10 (10 is worst), discharge vital signs (must be stable), mental alertness level, ambulatory vs. wheelchair.

c. Operative site: dressing intact, dry or amount of bleeding noted.

d. Accompanied by: Spouse relative friend other (record person and position i.e. BAS HM3 Jones).

e. Total Fluids: _____.

f. Follow up: Instructions given (record them).

g. Patient statement: I understand the above instructions + patient's signature.

Indicator Data Report Form

From: _____Department/Clinic
To: Performance Improvement Office
Via: Head, Anesthesiology

Provider: _____

Monitor: _____

1. The following data is reported for the month of: _____

2. Total number of sedation cases for the month: _____

   a. Total number of cases in this month that triggered one or more indicators (listed below):_____

   b. Total number of specific indicators triggered for the month (some cases trigger more than one indicator).*

(1) Unplanned ICU admission or transport	_____
(2) Unplanned hospital admission	_____
(3) Hemodynamic instability	_____
(4) Aborted procedure	_____
(5) SaO2 <90% despite 02	_____
(6) Significant nausea/vomitting	_____
(7) Prolonged recovery stay: (<1hr)	_____
(8) Use of naloxone	_____
(9) Use of flumazenil	_____
(10) Patient complaint (called or had need to return from pain/nausea/ ongoing emesis)	_____

Case specific reviews must be available: ie. Write on the record which complications occurred.

_____
Department Head (Signature/Stamp)

*These indicators pertain to the sedation used, not to the procedure itself.

RECORD OF CONSCIOUS SEDATION COURSE COMPLETION

This is to certify that_____has attended a one hour class on Conscious Sedation covering the NAVHOSP29PALMS Instruction, permitted locations, monitoring requirements, recommended medications, and documentation requirements.

Attendee_____Date_____

Instructor_____Date_____